

Heinz E. Lehmann: No surprises in psychiatry
John Court's comments

As we've become wonderfully accustomed, the late Prof. Heinz Lehmann's synopsis on this subject is insightful and thought-provoking, yet concise. Dr. Lehmann customarily responded generously to his many invitations to speak - both locally, as in this instance, and internationally. Hence we must approach assessing this opus in that context - not as a fully-formed, peer-reviewed article, but rather as Dr. Lehmann's own reading notes for a brief, local speaking engagement in Montréal.

I was intrigued - as an aside - that Dr. Lehmann (a professor of the anglophone McGill U.) had as usual prepared his reading notes in English, for delivering off-the-cuff *en français* to a facility whose working language had been French since the late-19th century. That speaks tacitly to Heinz's trilingual fluency. The historic *Asile Saint-Jean-de-Dieu* had by then evolved as the *L'Hôpital Louis LaFontaine*. Since then it has emerged as *L'Institut Universitaire en Santé Mentale de Montréal - affilié avec l'Université de Montréal*.

I wish we had known of this presentation notes ms. just last year when, by coincidence, my senior colleague, Prof. Benoit Mulsant (Chair of Psychiatry, University of Toronto) and I presented a grand rounds at a neighbouring teaching hospital (the University Health Network/ Toronto General Hospital) on a similar theme -- although we adopted a more recent time frame. We had been inspired to continue a discussion that was eloquently launched by Mark Micale's article (2014 - citation & excerpts are enclosed), commencing our survey, as had Micale, with the close of the Second World War.

John Court
November 10, 2016

PSYCHIATRY AFTER THE ATOMIC BOMB



What have been the most impactful changes in psychiatry since World War Two?

What do they tell us about the future of psychiatry?

UHN Psychiatry Grand Rounds
13 Nov. 2015

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Discussant

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Learning Reflections

- * Identify psychiatry's most significant changes over the past 70 years, since WW2**
- * Consider the impact of changes, both positive and negative – while acknowledging our subjectivity and vantage points**
- * Reflect whether particular changes may support or impede psychiatry in securing advancements for recovery, care and prevention**
- * Identify the desired changes that we feel should have priority**

Session Outline



1. **What's history got to do with it?**
2. **Why WW2?**

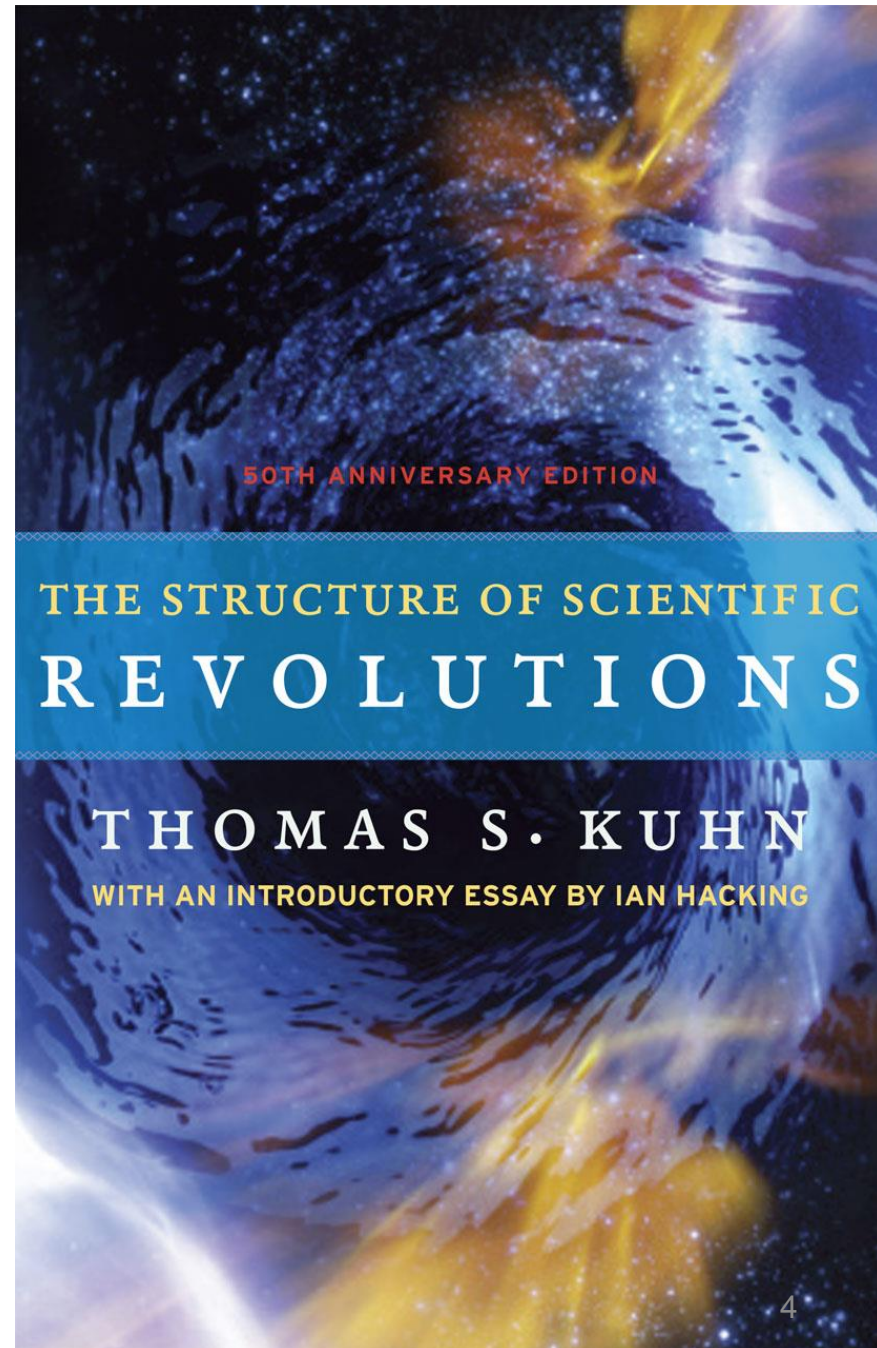
THE MOST IMPACTFUL CHANGES IN PSYCHIATRY

3. **What is the range of perspectives?**
 - e.g., patient, family member, or other lived experience; service providers; independent observer-analysts
4. **What are the dimensions of change?**
 - paradigm shift, silo-busting, a substantial internal change, or an incremental change
5. **What does the research evidence tell us?**
6. **Conclusions: how can we advance this discussion?**

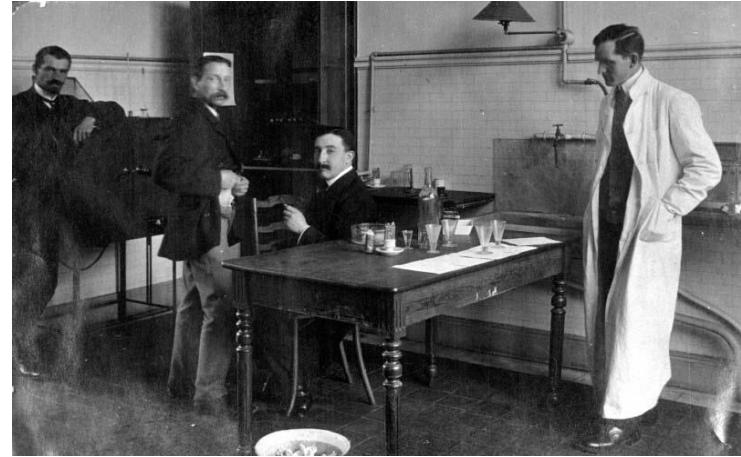
A theoretical framework

(50th Anniversary ed., 2012)

1. **Normal science** – experimental method, working within the established paradigms (conceptual models, or exemplars)
2. **Anomalies** often arise – generally resolved within, or by advancing existing paradigms; when anomalies persist ...
3. **Crises** of interpretation ensue; where persisting, possibly a ...
4. **Scientific revolution** – giving rise to a **paradigm change** or **shift** – an altered world view that is **incommensurable**; e.g., Newtonian physics, Einstein's Relativity, Darwin's *Origins*.



History's Value for Psychiatry and Medical Science

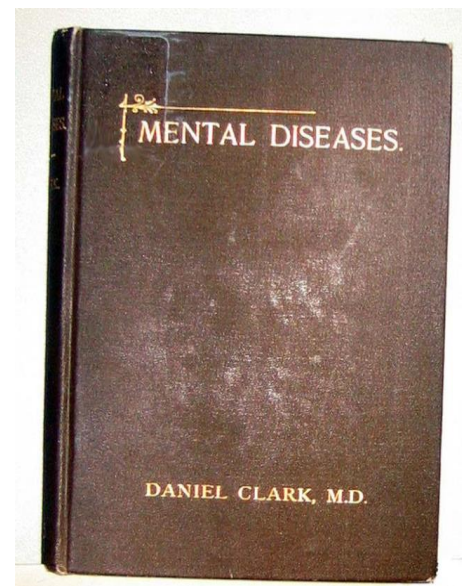
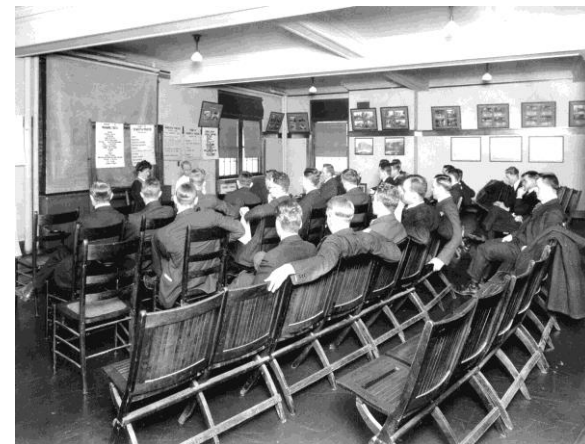


- ❑ **Expanding our awareness for revealing errors**
- ❑ **Detecting distortions in knowledge as applied to patient care**
- ❑ **Helping avoid mistakes in public policy, e.g., early 20th century's extreme eugenic concepts**
- ❑ **A perspective for insights on possible trends.**
- ❑ **Concluding: History seldom provides direct answers - rather, a context within which to seek them.**

Musto DF (1978), *Am J Psychiatry* 135 (July), Supplement, 22-6

History's Benefits for Health Professional Learning

- **“The history of medicine is said to:**
- **contextualize medical practice;**
- **reveal the provisional and fallible nature of medical knowledge;**
- **foster a cautiousness and humility in the medical thinker;**
- **complement the teaching of bioethics through illustrative real-life examples;**
- **instill humanity in medicine’s white-coated experts;**
- **improve the skills of medical history-taking and constructing;**
- **improve the skills of critical appraisal and interpretation of evidence;**
- **promote scholarship, and contribute positively to professional identity-formation.”**



Fuller, J. and Olszewski, M.M. (2013). “Medical History in Canadian Under-graduate Medical Education, 1939 – 2012,” *CBMH/BCHM*, 30:2, 200.

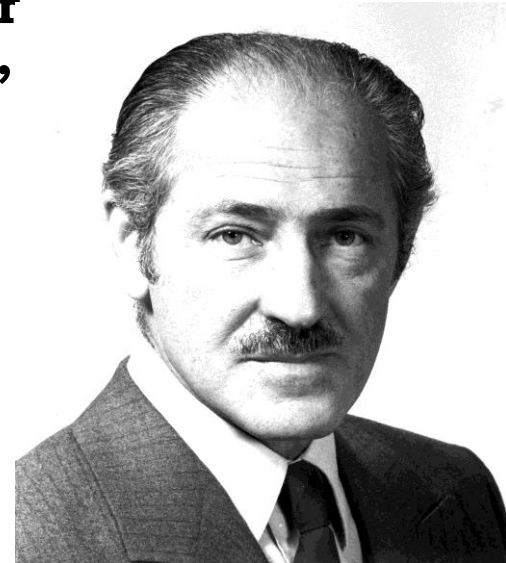
WW2 – The Atomic Bomb

- ❖ **Toronto psychiatrist Eric Clarke, son of C.K., became Chief Psychiatrist for the Manhattan Project at Oak Ridge, TN and Los Alamos, NM**



- ❖ **In contrast, Toronto's recently-deceased Dr Ab Miller had returned home from the U.S., enlisting as a Canadian Army psychiatrist. Ab then served at TPH, Queen Street, the Clarke Institute and Sunnybrook as our longest-serving faculty member – 60 years**

From his lengthy and varied perspective, Dr. Miller contended that the Second World War was the fundamental catalyst for psychiatry's crucial turning point (*)



(*) Videotaped personal interview by Dr. David Goldbloom, Nov. 2000, CAMH Archives.

RESEARCH ON PSYCHIATRY'S MOST IMPACTFUL POST – WW2 CHANGES (Micale, 2014)

A. Informal Survey of ca. 200 Mental Healthcare Providers – 2011-14

1. The ‘psychopharmacology revolution’ of the 1950s.
2. Deinstitutionalization, or the movement of massive numbers of psychiatric patients out of state asylums into community health care facilities.
3. The ‘decline and fall’ of psychoanalysis.
4. Shifts in the practice of psychotherapy from psychiatrists to non-medical professionals, especially clinical psychologists and clinical social workers.
5. The rise of a vast scientific research programme, including massive institutional and financial resources, for studying the neurochemistry and neurobiology of mental illness.
6. The introduction and widespread adoption since the 1980s of a new generation of anti-anxiety and anti-depressant compounds, especially the so-called SSRIs such as Prozac (fluoxetine).
7. A steady increase in the influence of the pharmacology industry throughout the psychiatric profession (e.g. ‘big pharma’).
8. The growth in influence of the *Diagnostic and Statistical Manual of Mental Disorders*.
9. The multiplication of ‘new’ diagnoses.
10. The de-pathologizing of homosexuality.

Micale, Mark S., “The Ten Most important Changes in Psychiatry since WW2,” *History of Psychiatry*, 25:4 (Dec. 2014), 485-491.



B. Invited Individual Response – Henry A. Nasrallah, MD

“Henry A. Nasrallah, M.D, is Professor and Chair of the Department of Neurology and Psychiatry at the St. Louis University Medical School in St. Louis, Missouri. Asked what he regarded as the 10 greatest changes in psychiatry since the end of World War II, Dr. Nasrallah answered as follows:

1. The establishment of the National Institute of Mental Health (1949).
2. The discovery of psychotropic medications in the 1950s and 1960s.
3. Passing of the Community Mental Health Act as part of President Kennedy’s New Frontier Program, 1963.
4. The publication of DSM-III, a major theoretical departure from earlier DSMs.
5. Massive deinstitutionalization and the subsequent criminalization of the mentally ill.
6. The discovery in the 1970s and 1980s of an array of noninvasive diagnostic neuroimaging techniques (MRI, CBF, CT, PET and SPECT) that in turn led to the discovery of numerous structural and functional brain abnormalities in mental illness.
7. The rise of biological psychiatry.
8. Advances in molecular genetics that have helped to identify the complex genetics of some psychiatric disorders.
9. The discovery of neuromodulation techniques (Deep Brain Stimulation, Vagus Nerve Stimulation, Repetitive Transcranial Magnetic Stimulation, and others), which may one day replace pharmacotherapy.
10. The advent of evidence-based psychotherapies, such as Cognitive Behavioral Theory, Interpersonal Psychotherapy, and Dialectical Behavior Therapy.”

C. Invited Individual Response – Jane Tillman, PhD, ABPP

“Jane Tillman, PhD, ABPP, is a clinical psychologist and psychoanalyst who currently heads the Erikson Institute for Education and Research at the Austen Riggs Center in Stockbridge, Massachusetts. Dr Tillman offered this informed set of responses to my question, which she conscientiously compiled with dates in neat chronological order:

1. 1947: Penicillin is confirmed as an effective treatment for syphilis. Cases of tertiary syphilis and the functional psychosis associated with them that filled state mental hospitals can now be removed and treated.
2. 1947: The Nuremberg Code creates a set of international ethics principles for human experimentation, including a requirement for informed consent from human research subjects.
3. 1948: Dr. John Cade discovers that lithium salts is an effective mood stabilizer in the treat1948: Dr. John Cade discovers that lithium salts is an effective mood stabilizer in the treatment of ‘manic depression.’
4. 1952: First use of the anti-tuberculosis drug Isoniazid in depressed patients and coining of the term, ‘anti-depressant.’
5. 1967: Otto Kernberg publishes his first paper on Borderline Personality Organization in the Journal of the American Psychoanalytic Association.
6. 1973: The American Psychiatric Association declassifies homosexuality as a mental illness.
7. 1981: The publication of Judith Lewis Herman’s book Father-Daughter Incest begins to bring the very secretive world of child sexual abuse to public attention.
8. 1985: Four psychologists successfully sue the American Psychoanalytic Association for restriction of trade, and psychologists are admitted to psychoanalytic institutes across the United States, leading to the further demedicalization of psychoanalysis.
9. 1987: Prozac wins approval by the U.S. Food and Drug Administration.
10. 2013: For the first time, psychiatrists top the list of Big Pharma payments to individual physicians.

D. Micale's Other Noteworthy Responses

i) The Runners-up – # 11 and 12

11. Sub-fields of psychiatry since 1945 – geriatric psychiatry and child psychiatry [also, officially in Canada, forensic psychiatry].
12. Economic aspects, notably (a) the mental health insurance industry [or governmental role] and managed care models of health services; (b) the spiraling cost of medical education.

ii) Anticipated but Infrequent or Omitted Responses

1. Psychiatric genetics.
2. The formation of mental patient rights organizations.
3. The Mental Health Recovery Movement.
4. Changing laws affecting psychiatrists, and increasingly litigiousness.
5. Discredited mid-century somatic treatments, esp. psychosurgery.
6. The dramatic emergence during the 1960s and '70s of the powerful, multi-faceted anti-psychiatry movement – notably Szasz, Foucault, Laing.
7. Psychiatry's gender revolution – the dramatic increase of women.
8. A heightened sensitivity to issues of gender, class, race and religion in the diagnosis and treatment of patients.

Which Major Post-WW2 Impacts should we add to those already acknowledged, or re-order in priority?

Which ones will aid most in advancing health & wellness?

1. **Combating Stigma** – steadily eroding prejudice and discrimination against MI to raise confidence & self-respect, and improve pathways to care.
2. **Neuroscience, including genetics and DNA research, non-invasive brain therapies, PET scanning** with an array of present and prospective benefits:– diagnostic; early intervention; associating disorders with specific brain sectors or lesions; individually-tailoring therapies and/or medication dosages.
3. **The emergence of the new psychotherapies** (CBT, IP, DBT, etc.) and their demonstrated efficacy when employed in conjunction with **neuroscience and other biological psychiatry**, as recommended by the MHCC (2012, 61).

Continued ...

Which ones will aid most - *continued*

4. The acceptance into psychiatry of certain severe ailment categories formerly isolated and even disparaged, notably **addictions** (commencing with alcoholism) and **eating disorders**.
5. Current era's **Support Technology for KT** – the application of digital and web-based systems for patients' records and communicating clinical, educational and research knowledge.
6. Strategies articulated and under way through **the Mental Health Commission of Canada**, such as the multi-centred *At Home/ Chez Nous* research program.
7. Focus on physical and mental co-morbidities through the **Medical Psychiatry Alliance** – coordination-integration for interdisciplinary mental health with other medical services while integrating patients' health needs.
8. **Global Mental Health** – “aiming to bolster the initiatives of health care professionals throughout the world by introducing an innovative, adaptable holistic policy and intervention framework...” (Akwatu Khenti, *CAMH Daily Broadcast*, 3 Sept. 2015)